

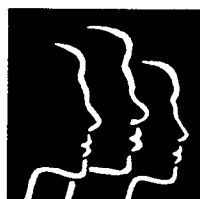
# **COMMUNITY CARE LICENSING DIVISION**

*"Promoting Healthy, Safe and  
Supportive Community Care"*

## **TECHNICAL SUPPORT PROGRAM**

### **Self-Assessment Guide**

# **FOSTER FAMILY AGENCY PREADMISSION QUESTIONNAIRE**



**CDSS**

CALIFORNIA  
DEPARTMENT OF  
SOCIAL SERVICES

# TECHNICAL SUPPORT PROGRAM

## FOSTER FAMILY AGENCY

### PREADMISSION QUESTIONNAIRE

The following questionnaire is designed to assist foster family agency staff to identify specific issues that may affect the placement of and/or services to be provided to prospective residents of Foster Family Agency (FFA). Depending upon the needs of the child and facility program additional information may need to be gathered prior to the placement of a child in the facility. The questions on this form should be reviewed with the child's placement worker prior to admission to the facility. If the answer to any of the questions on this form is yes; the intake staff should gather information to determine whether or not the facility will be able to admit the resident and meet his/her needs.

The information on this form supplements the Needs and Services Plan form (LIC 625), but does not replace it. While the information gathered from this form should assist staff in making appropriate placement decisions, it is not a required form and does not constitute a preadmission appraisal.

Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Current Residence: \_\_\_\_\_

Placement Status: Voluntary \_\_\_\_\_ 300W&I \_\_\_\_\_ 602W&I \_\_\_\_\_

Reason for Placement: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

YES NO

☐ ☐

Is the child a registered sex offender? (Information required per H & S 1522.01) If yes, please provide information on offense(s) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

#### A. ABUSE/NEGLECT

Does the child have a history as a victim of any of the following:

YES NO

☐ ☐

☐ ☐

☐ ☐

☐ ☐

☐ ☐

☐ ☐

☐ ☐

☐ ☐

1. Physical abuse

2. Sexual abuse

3. Abandonment

4. Emotional abuse

5. Neglect

6. Medical neglect

7. Ritualistic abuse

If the answer to any of the above questions is yes, please describe:

The type and extent: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ABUSE/NEGLECT (continued)**

Any therapy the child has received or requires:\_\_\_\_\_

Any special precautions to be taken in the care of the child:\_\_\_\_\_

**B. DELINQUENCY**

Does the child have a history of any of the following:

YES   NO

- |                          |                          |                                     |
|--------------------------|--------------------------|-------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Offenses against people          |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Offenses against property        |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Drug or alcohol related offenses |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Use of weapons                   |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Arson                            |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Sexual Offenses                  |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Truancy                          |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Runaway                          |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Gang activity                    |

If the answer to any of the above questions is yes, please describe:

The type and frequency of the activity:\_\_\_\_\_

The approximate date of the last involvement in the activity:\_\_\_\_\_

Gang affiliation, if any:\_\_\_\_\_

**C. MENTAL/DEVELOPMENTAL STATUS**

Do any of the following apply to the child:

YES   NO

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Mental disorder (DSM, current revision, diagnosis)                        |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Developmental disability  |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Deficits in self help skills  |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Requires psychotropic medications   |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Special education pupil, certified, Seriously Emotionally Disturbed (SED) |

If the answer to any of the above questions is yes, please provide the following information:

Is the child eligible for and/or receiving services through a Regional Center? If yes, please give the provider name and summary of services:\_\_\_\_\_

## MENTAL/DEVELOPMENT STATUS (continued)

Does the child have a DSM diagnosis? If yes, please list any past or current treatment\_\_\_\_

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Has the child ever been an inpatient of a mental health facility or developmental center?  
If yes, please provide the dates, reasons, and location of hospitalizations:\_\_\_\_\_

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### D. HEALTH STATUS

Child's primary physicians name and phone:\_\_\_\_\_

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YES   NO

☐   ☐

Does the child use any prescription medications? If yes, please list  
prescription:\_\_\_\_\_

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☐   ☐

Does the child use any nonprescription medications? If yes, please list non  
prescription:\_\_\_\_\_

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Does the child have any of the following:

YES   NO

☐   ☐

1. Asthma

☐   ☐

2. Epilepsy

☐   ☐

3. Allergies

☐   ☐

4. Diabetes

☐   ☐

5. Eating disorder

☐   ☐

6. Visual impairment

☐   ☐

7. Hearing impairment

☐   ☐

8. Infectious disease

☐   ☐

9. Special diet

☐   ☐

10. Pregnancy

☐   ☐

11. Chronic medical conditions

☐   ☐

12. Physical limitations

If the answer to any of the above is yes, please describe

The type and severity of the condition:\_\_\_\_\_

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The treatment the child is receiving for the condition:\_\_\_\_\_

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Any medical apparatus the child needs as a result of the condition:\_\_\_\_\_

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## HEALTH STATUS (continued)

Any limitations due to the condition: \_\_\_\_\_

Any special services required due to the condition: \_\_\_\_\_

### E. ALCOHOL/DRUG USE

Does the child have a history of any of the following:

YES   NO

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Drug use                              |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Alcohol use                           |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Use of inhalants                      |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Use of injectable drugs               |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Treatment for drug abuse              |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Treatment for alcohol abuse           |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Abuse of over the counter medications |

If the answer to any of the above is yes, please describe:

Types of drugs, alcohol or inhalants used: \_\_\_\_\_

Frequency of use of the above: \_\_\_\_\_

Approximate date of last known use of the above: \_\_\_\_\_

Current or past treatment programs for substance abuse and dates of treatment: \_\_\_\_\_

### F. BEHAVIORS

Does the child have a history of any of the following:

YES   NO

- |                          |                          |                                  |
|--------------------------|--------------------------|----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Non-compliance                |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Resistance to authority       |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Temper tantrums               |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Verbal abusiveness            |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Physical assaultiveness       |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Property destruction          |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Violence toward self          |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Restlessness or hyperactivity |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Depression or withdrawal      |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Anxiety                      |

## BEHAVIORS (continued)

If the answer to any of the above is yes, please describe:

The behaviors: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The frequency and duration of the behaviors: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The approximate date of the last occurrence of the behaviors: \_\_\_\_\_

Anything that seems to trigger the behaviors: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Strategies to deal with the behaviors: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does the child have a history of any of the following:

YES   NO

- |                          |                          |                                    |
|--------------------------|--------------------------|------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Mood swings                     |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Suicidal ideations              |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Suicide attempts                |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Paranoia                        |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Hallucinations                  |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Fire setting                    |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Cruelty to others               |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Cruelty to animals              |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Inappropriate sexual behavior   |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Confusion with sexual identity |

If the answer to any of the above is yes, please describe:

The behaviors: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The frequency and duration of the behaviors: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The approximate date of the last occurrence of the behaviors: \_\_\_\_\_

Anything that seems to trigger the behaviors: \_\_\_\_\_  
\_\_\_\_\_

## BEHAVIORS (continued)

Strategies to deal with the behaviors: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does the child have a history of any of the following:

YES   NO

- |                          |                          |                                  |
|--------------------------|--------------------------|----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Sexual assaultiveness         |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. AWOL                          |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Ingestion of toxic substances |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Attempts to poison others     |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Disruptiveness                |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Refusal to take medications   |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Refusal of medical treatment  |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Refusal to attend therapy     |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Stealing                      |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Other (describe) _____       |

If the answer to any of the above is yes, please describe:

The behaviors: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The frequency and duration of the behaviors: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The approximate date of the last occurrence of the behaviors: \_\_\_\_\_  
\_\_\_\_\_

Anything that seems to trigger the behaviors: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Strategies to deal with the behaviors: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Placement Worker: \_\_\_\_\_  
Date: \_\_\_\_\_  
Facility Representative: \_\_\_\_\_  
Date: \_\_\_\_\_